

COMMUNITY HEALTH NEEDS ASSESSMENT IMPLEMENTATION STRATEGY

Mercy Health – Anderson Hospital

IDENTIFYING INFORMATION

Hospital Name: Mercy Hospital Anderson dba Mercy Health – Anderson Hospital

Primary Address: 7500 State Road; Cincinnati, Ohio 45255

Implementation Strategy Tax Year: 2014

Tax Identification Number: 31-0537085

Chief Executive Officer: Jeff Graham, President, and Market Leader-East Region

Date Implementation Strategy Approved by Board: _____

Due Date for Form 990 Filing that Includes Implementation Strategy: _____

PRIORITIZATION OF HEALTH NEEDS

The county level results of HCAN's *A Community Health Needs Assessment for Southwest Ohio and Southeast Indiana* were supplemented with additional data from the following sources:

- "By the Numbers," Mental Health Advocacy Coalition.
- Cancer Incidence and Mortality; Ohio Cancer Incidence Surveillance System.
- Chronic Disease Indicators; State/Area Profile; CDC's National Center for Chronic Disease Prevention and Health Promotion; <http://apps.nccd.cdc.gov> accessed September 4, 2012.
- Clermont County Vital Statistics; Clermont County General Health District.
- County Health Rankings & Roadmaps; www.countyhealthrankings.org
- Diagnoses for All Hospital Admissions per Service Area (by zip code); Ohio Hospital Association.
- Mercy Health Self-pay and Charity Financial Classes Seen in the Emergency Departments, 2011.
- Policy Brief: Mental Health in Ohio; Health Policy Institute of Ohio, September 2009.
- Top 10 Causes of Death in Cincinnati, 2001-2007, City of Cincinnati.

Priorities were established among identified health needs using a multi-level process incorporating the perspective of major stakeholders in the local community as defined in the IRS Notice and are relevant to the hospital's defined service area. Local community leaders were invited to join hospital leaders and regional representatives for one scoring session. They were provided a list of health needs, conditions, or issues with data from HCAN's report and the sources above, as relevant.

This process involved the scoring of each identified health need based on selected key criteria. Each criterion was also assigned a weight based on its relative importance in relation to the other key criteria. This scoring method created a rank order among the identified health needs.

IDENTIFIED COMMUNITY HEALTH PRIORITIES

- Mental Health
- Diabetes
- Heart Disease
- Access to Care

Mental Health

Initiate a collaborative care model structured like the IMPACT program as developed by The University of Washington. This model will be developed and implemented within the 2013 /2014 time frame.

The model consists of five essential elements:

Collaborative care is the cornerstone of the IMPACT model

- The patient's primary care physician works with a care manager to develop and implement a treatment plan (medications and/or brief, evidence-based psychotherapy)
- Care manager and primary care provider consult with psychiatrist to change treatment plans if patients do not improve

Depression Care Manager - This may be a nurse, social worker or psychologist and may be supported by a medical assistant or other paraprofessional. The care manager:

- Educates the patient about depression
- Supports antidepressant therapy prescribed by the patient's primary care provider if appropriate
- Coaches patients in behavioral activation and pleasant events scheduling
- Offer a brief (six-eight session) course of counseling, such as Problem-Solving Treatment in Primary Care
- Monitors depression symptoms for treatment response
- Completes a relapse prevention plan with each patient who has improved

Designated Psychiatrist:

- Consults to the care manager and primary care physician on the care of patients who do not respond to treatments as expected

Outcome measurement:

- IMPACT care managers measure depressive symptoms at the start of a patient's treatment and regularly thereafter. Consideration will be given to the PHQ-9 as a measurement tool.

Stepped care:

- Treatment adjusted based on clinical outcomes and according to an evidence-based algorithm
- Aim for a 50 percent reduction in symptoms within 10-12 weeks
- If patient is not significantly improved at 10-12 weeks after the start of a treatment plan, change the plan. The change can be an increase in medication dosage, a change to a different medication, addition of psychotherapy, a combination of medication and psychotherapy, or other treatments suggested by the team psychiatrist.

Source: (<http://impact-uw.org>)

Diabetes

In greater Cincinnati, as part of the Robert Wood Johnson Foundation's Aligning Forces for Quality, a special focus has been placed on improving outcomes for people with diabetes. A majority of community based primary care physicians are now voluntarily reporting their population level outcomes for people with diabetes towards the goal of improving A1C scores. As a community, we have moved from 15% compliance with all five measures to 31% compliance.

Diabetes related initiatives specific to Mercy Health Anderson Hospital's community include:

- Pre-diabetes classes
 - Pre-diabetes is a condition that forms before diabetes. It means that blood sugar levels are higher than normal but aren't high enough to be diagnosed as diabetes. Usually a fasting blood sugar level of 100-125 mg/dl indicates pre-diabetes. Pre-diabetes is a warning sign that allows people to take action to prevent or delay the onset of Type 2 diabetes. Diabetes educators who are also registered dietitians teach Mercy Health's pre-diabetes classes. Each class includes information on making healthy food choices, exercise and blood sugar control, monitoring blood sugar levels.
- Wellness classes, weight management and fitness programs offered through the HealthPlex, a state-of-the art fitness and wellness facility located on the campus of Mercy Health Anderson

Hospital. While these resources are currently available to club members only, an evaluation will be conducted to identify options for expanding programs to include publically available diabetes management educational programming

- Educational events on diabetes and weight management are offered at different times during the year in conjunction with our Mercy Women program and at local middle school health fairs.
- Diabetic screening and treatments for indigent patients are provided through the Mercy Care Clinic and the Catherine McAuley Health Center, both hospital sponsored programs.

Heart Disease

Mercy Health-Anderson Hospital has made great strides in recent years in expanding the scope of cardiovascular services it provides. Today, from an acute care perspective, they offer a comprehensive set of services including open heart surgery, cardiac catheterization and electrophysiology.

Comprehensive, quality care delivered within our communities is a hallmark of our philosophy.

From a more preventive / health maintenance perspective, Mercy Health-Anderson Hospital offers:

- The Heart Institute of Mercy Health has teamed with HealthFair, the national leader in mobile screening services, to deliver affordable and convenient mobile heart screenings and extend Mercy Health's network of care throughout Cincinnati. HealthFair is the only mobile screening company with Joint Commission Accreditation, ensuring superior quality and dedication to customer service. This mobile service visits the communities served by Mercy and offers several value priced screening packages to test people for their risk of heart attack, stroke, aneurysm and other major diseases.
- Provision of community health fairs / screening events that include screening for blood pressure and cholesterol levels.
- Mercy Health is a corporate sponsor of the Heart Mini-Marathon and the Forest Hills 5K which both raise community awareness and support for heart disease and stroke.
- Promote healthy lifestyles, wellness and fitness through our on-campus HealthPlex facility. Investigate funding sources to increase the provision of free educational programming for the community both at the HealthPlex and the hospital campus.
- Continue the ongoing Mercy Health Physician and Mercy Women lecture series and ensure sufficient program content on cardiovascular issues

- Blood pressure screening as well as physician and RN visits through the Catherine McAuley Center
- Continuing care for heart disease patients without insurance at the Mercy Care Clinic

Access to Care

Mercy Health-Anderson Hospital has been concerned and proactive with community access to care issues for many years. Multiple programs have been developed in response and will continue to operate in the coming years of this implementation plan. The programs range from providing care and coordinating financial assistance for indigent patients to more overall population health management initiatives. Programs currently operating include:

- Emergency Department Medical Home Advocate – finds primary care physicians for those without medical care. Coordinate resources and data collection.
- Case Management in the Emergency Department – case management coordinates inpatient - outpatient transitions and targets interventions for high risk and mental health patients.
- Transition Nurses – Post-hospital follow up of high risk patients and facilitate access to care post discharge
- Cancer Family Care – Mercy Health Anderson Hospital supports this organization to provide mental health counseling services for Mercy Anderson patients and their families dealing with cancer
- Pharmacy Medication Access Program – serves patients in the community or those being discharged who cannot afford or access needed prescriptions. Approximately \$17,000 in 2012.
- Catherine McAuley Health Center - provides education, coordination of services and some no – cost physician visits
- Mercy Care Clinic – provides primary care for the uninsured without resources. Approximate financial support from hospital in 2012 was \$58,000.
- Mercy Health Anderson Hospital OB Clinic – Social workers and an OB Gyn physician provide services in the clinic setting for indigent mothers. This clinic has been recently expanded to provide follow up gynecology care.
- Nurse Navigator in the Women’s Health Center – an RN provides coordination of care, helping patients access financial assistance